REDACTED

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	D-3572
MILOS KLVANA, M.D. 24456½ Lyons Avenue Newhall, CA 91321	)	N-42720
Physician and Surgeon Certificate No. A29719,	)	
Respondent.	)	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective on Jan. 15, 1994.

IT IS SO ORDERED December 16, 1993.

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By Theresa L. Claassen

THERESA L. CLAASSEN
Secretary/Treasurer

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Respondent.	

PROPOSED DECISION

This matter came on for hearing before Richard J. Lopez, Administrative Law Judge of the Office of Administrative Hearings (OAH), at Atascadero State Hospital, California on June 30, 1993.

Elisa B. Wolfe, Deputy Attorney General, represented the complainant.

Respondent appeared in person and represented himself.

Oral and documentary evidence and evidence by way of stipulation and official notice was received and the matter then argued and thereafter submitted on September 7, 1993, after the filing of post-hearing briefs as set forth in Finding 6.

The Administrative Law Judge now finds, determines, and orders as follows:

PARTIES AND JURISDICTION

1

Dixon Arnett, Complainant herein, brought subject Second Supplemental Accusation in his official capacity as Executive Director of the Medical Board of California (MBC), Department of Consumer Affairs, State of California.

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On or about October 31, 1975, MBC[1] issued Physician's and Surgeon's Certificate No. A 29719 to Milos Klvana, M.D., respondent herein.

3

On or about March 14, 1980, the MBC revoked respondent's physician's and surgeon's certificate, but stayed said revocation and placed the certificate on probation for five (5) years, pursuant to its February 13, 1980 Decision and Order in the case entitled "(In the Matter of the Accusation Against Milos Klvana, M.D.," Board Case No. D-2248 (OAH Case No. L-17972).[2]

4

(A) On or about August 17, 1981, MBC modified the probationary terms and conditions by its July 16, 1981 order in said MBC case (OAH Case No. N-16934). On or about March 3, 1983, MBC granted respondent's petition to terminate probation and hence restored respondent's certificate to full force and effect (OAH Case No. N-20157). On or about June 30, 1988, respondent's certificate expired and has not been renewed since its expiration.

(B) On or about March 2, 1988, in the case entitled, "Board of Medical Quality Assurance v. Milos Klvana, M.D., Los Angeles Superior Court case no. C 678202, the Court issued a Temporary Restraining Order against respondent's physician's and surgeon's certificate.

5

On or about April 13, 1988, the Court ordered that a Preliminary Injunction issue against respondent's physician's and surgeon's certificate. The Preliminary Injunction, duly served

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[1]On January 1, 1990 the Board of Medical Quality Assurance became the Medical Board of California.

[2]The instances of unprofessional conduct which constituted grounds for this 1980 disciplinary action were: [1] a 1979 conviction of 26 counts of violating Health and Safety Code §11154 (prescribing a controlled substance to a person who is not under treatment for a pathology or condition other than addiction to a controlled substance), and [2] prescribing, to persons not under his care for a pathology or condition, controlled substances without a good faith prior examination or without medical indication therefor.

on all apparently interested parties, provided that: (1) respondent shall not practice medicine, (2) respondent shall not supervise physician's assistants, (3) respondent shall not violate the Medical Practice Act, (4) respondent shall not possess, order, purchase, furnish, receive, prescribe, dispense, administer, or otherwise distribute dangerous drugs or controlled substances, (5) respondent shall not possess, order or receive any DEA 222c forms, (6) respondent shall not possess, order, or receive any blank prescription pads or unused triplicate forms, and (7) the Preliminary Injunction shall remain in effect until further order of the Court. Said preliminary injunction currently is in full force and effect.

6

In this proceeding the record was held open to allow post-hearing briefs as follows:

On July 18, 1993 complainant filed same, which was marked and received as Exhibit 7 for identification.

On July 30, 1993 respondent filed a response thereto, marked and received as Exhibit A for identification.

On September 7, 1993 complainant filed a closing brief, marked and received as Exhibit 8 for identification. The case was then deemed submitted.

The briefs were read and considered.

7

All prehearing requirements have been met. Jurisdiction for this proceeding does exist.

FINDINGS OF FACT
RE: SECOND SUPPLEMENTAL
ACCUSATION

8

On or about February 5, 1990, in the case entitled, "People of the State of California v. Milos Klvana," Los Angeles Superior Court Case No. A791288, respondent was found guilty, by jury, and thus convicted of violating the following provisions of law:

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Code §§ Violated		No. of Counts [Criminal Complaint][3]
(A)	*Penal §187(a) [Second Degree Murder, a felony]	9 [Count nos. 1-4,8,20,23,25,31]
(B)	*B&P §2053 [Aiding and Abetting the unlicensed Practice of Medicine, a felony]	5 [Count nos. 10,22,27,30,33]
(C)	*Penal §182(1)/B&P §2053 [Conspiracy to Practice Medicine Without a License, a felony]	1 [Count no. 52]
(D)	*Insurance §556(a(3) [Preparing Fraudulent Insurance Claim, a felony]	19 [Count nos. 5,11-13,15-17,29, 36-41,44-46,49,50]
(E)	*Insurance §556(a)(1) [Presenting Fraudulent Insurance Claim, a felony	10 [Count nos. 6,15,18,28,34-36, 47,58,51]
(F)	*Penal §487(1) [Grand Theft, a felony]	2 Count nos. 7,19]
(G)	*Penal §118 [Perjury by Declaration, a felony]	2 Count nos. 42,43]

Respondent's criminal conduct, set forth in Finding 8, separately as to each count and severally, are substantially related to the qualifications, functions and duties of a physician and surgeon and, accordingly does constitute unprofessional conduct.

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[3]The "count numbers" from the "Criminal Complaint" correspond to the criminal counts set forth in the **Amended Information** filed in Los Angeles Superior Court case no. A791288. For sake of convenience, reference is made throughout this Decision to the count numbers in said Amended Information.

The facts and circumstances behind respondent's nine second degree murder convictions[4] are detailed in People v. Klvana (1992) 11 Cal. App. 4th 1679. Those facts and circumstances, here officially noticed, are summarized briefly as follows: Respondent, who resigned from residency programs in obstetrics-gynecology and anesthesiology due to his deficient medical judgment and a resultant patient death, was warned by one supervisor that he had a cavalier attitude and should avoid fields of medicine which require moment-to-moment attention to patient status. In 1977, respondent proceeded to pursue a career in obstetrics in Southern California but experienced difficulty maintaining privileges at the various hospitals where he practiced. In 1980, respondent purchased the Diet-Rite Medical Clinic and commenced performing outpatient vaginal delivery of babies at said clinic. In his obstetrical practice, respondent utilized the services of non-physicians in monitoring pregnancies, performing deliveries, and providing follow-up care.

From 1982 through 1986, respondent maliciously caused the deaths of at least nine infants which he delivered. Among the many factors behind the deaths are these: Respondent repeatedly ignored obvious, basic indicia of high-risk pregnancies (e.g., meconium[5] staining, Rh factor) and failed to monitor or manage said risks properly (e.g., lack of emergency hospital referral, insufficient fetal monitoring, failure to provide neonatal care). Respondent disregarded multiple warnings

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[4]A summary of the murder convictions:

Criminal Count No.	Surname of Infant's Mother	Date of Death
1	J[redacted]	[redacted]
2	F[redacted]	
3	J[redacted]	
4	G[redacted]	
8	D[redacted]	
20	E[redacted]	
23	F[redacted]	
25	P[redacted]	
31	L[redacted]	

[5]Meconium is fetal excrement. The presence of meconium is an indication of fetal distress.

from peers about inadequacies in his practices (e.g., the need for high-risk deliveries to be performed in a hospital). Respondent repeatedly omitted and/or misrepresented material information about his professional standing (licensure, hospital privileges), about the sophistication of his practice (clinic equipment, ability to handle emergencies), and about the patient's medical options (e.g., advisability of Caesarean section delivery). Respondent repeatedly administered the drug Pitocin improperly and failed to manage the risks presented by said drug. Respondent instructed patients reporting infant distress to stay away from hospitals or other emergency care. Respondent repeatedly requested that the parents of the deceased infants assist him in suppressing facts about their child's death.

11

The facts and circumstances behind respondent's convictions of violating B&P §2053 (Aiding and Abetting the Unlicensed Practice of Medicine) were charged and found as follows: Delores Doyle (a "certified nurse assistant" and respondent's co-defendant in Los Angeles Superior Court case no. A791288) has not at any time held a license to practice medicine in the State of California. Between November 9, 1983 and June 17, 1985, inclusive, respondent and Delores Doyle wilfully and unlawfully practiced and attempted to practice medicine, advertised and held themselves out as practicing, a system and mode of treating the sick and afflicted in this state, and did diagnose, treat, and operate for an ailment, deformity, disease, disfigurement, disorder, injury and other physical and mental conditions of persons, to wit, Lanna D[redacted] and Aaron D[redacted] [count 10], Kim E[redacted] and Tyrone E[redacted] [count 22], Lorraine A[redacted] [count 30], and Tosha W[redacted] L[redacted] [count 33] under circumstances and conditions which caused or created risk of great bodily harm, serious physical or mental illness, and death, without delores Doyle having at the time of so doing a valid, unrevoked, or suspended license and certificate.

12

The facts and circumstances behind respondent's conviction of violating Penal Code §182[1] (Conspiracy to Commit a Crime, to wit, B&P §2053, Practicing Medicine Without a License) were charged and found as follows: from on or about September 1982 through October 1986, respondent and other individuals wilfully and unlawfully conspired together to practice medicine without a license. Pursuant to said conspiracy and for the purpose of carrying the objects and purposes of the conspiracy, respondent and other individuals committed numerous overt acts involving (1) the actual provision of obstetrical care and management by a person not licensed to practice medicine during the prenatal, labor, delivery, and post-partum phases of

the pregnancies of numerous women; (2) the falsification of insurance claims as to the true provider of the obstetrical care, the circumstances under which babies were delivered (e.g., home, clinic), and the charges incurred during the obstetrical care; (3) the falsification of Certificates of Live Birth; (4) concealment of remuneration to the unlicensed practitioners of medicine.

13

The facts and circumstances behind respondent's convictions of violating Insurance Code §556(a)(3) (Preparing Fraudulent Insurance Claims) were charged and found as follows: respondent wilfully, unlawfully, and knowingly prepared, made, and subscribed to writings with intent to present and use said writings and to allow the said writings to be presented and used in support of a false and fraudulent claim for payment, as set forth in the chart below--

Criminal Count	Dates	Patient (p) or Victim (v)	Claim $$
5	11-9-82 to 2-10-83	Mira G[redacted] (p)	$1,400.00
11	10-30-83	Lanna L[redacted] D[redacted] (p)	$3,468.0
12	10-30-83	"	"
13	9-30-83	"	"
15	8-30-83 to 12-29-83	"	"
16	8-22-83 to 12-29-83	"	"
17	12-21-83 to 12-29-83	"	"
29	1-10-86	Hartford Insurance (v)	$ 645.00
36	4-29-86 to 7-21-86	Union Labor Life Insurance (v)	$ 555.00
37	6-23-86	Tosha W[redacted] L[redacted] (p)	$ 325.00
38	4-29-86 to 7-21-86	"	$ 335.00
39	4-29-86 to 7-21-86	"	$ 565.00

[c o n t i n u e d]

Criminal Count	Dates	Patient (p) or Victim (v)	Claim $$
40	7-16-86	"	$ 900.00
41	7-18-86	Daniel L[redacted] (p)	$ 555.00
44	2-10-83	Sandi S[redacted] (p)	$1,300.00
45	3-10-83	"	$ 700.00
46	3-10-83	Prudential Insurance (v)	$2,000.00
49	1-15-84	Ruby R[redacted] C[redacted] (p)	$1,930.00
50	1-15-84	"	$ 700.00

14

The facts and circumstances behind respondent's convictions of violating Insurance Code §556(a)(1) (Presenting Fraudulent Insurance Claims) were charged and found as follows: respondent wilfully, unlawfully, and knowingly presented and caused to be presented false and fraudulent insurance claims for payment, under contracts of insurance against loss, as set forth in the chart below--

Criminal Count	Dates	Patient (p) or Victim (v)	Claim $$
6	2-10-83	Blue Cross of California	$1,400.00
14	11-18-83	Prudential Insurance	$3,468.00
18	12-29-83	"	"
28	11-5-85 to 2-27-85	Amer. Consulting Engineers Council Trust Fund / Hartford Insurance	$ 465.00
34	5-31-86 to 7-2-86	AFTRA Pension and Welfare Funds / Union Labor Life Ins. Co.	$ 325.000
35	4-29-86 to 7-21-86	AFTRA Pension and Welfare Funds / Union Labor Life Ins. Co.	$ 900.00

[c o n t i n u e d]

Criminal Count	Dates	Patient (p) or Victim (v)	Claim $$
36	4-29-86 to 7-21-86	AFTRA Pension and Welfare Funds / Union Labor Life Ins. Co.	$ 550.00
47	3-4-83	Prudential Insurance	$1,300.00
48	3-14-83	Prudential Insurance	$2,000.00
51	1-15-84 to 2-13-84	Prudential Insurance	$2,630.00

15

The facts and circumstances behind respondent's convictions of violating Penal Code §487(1) (Grand Theft) were charged and found as follows:

(A) Count 7 - On or about April 5, 1983, respondent willfully and unlawfully took $1,060.64 from Blue Cross of California.

(B) Count 19 - Between December 1, 1983 and February 9, 1984, respondent willfully and unlawfully took $1,713.80 from Prudential Insurance Company.

16

The facts and circumstances behind respondent's convictions of violating Penal Code §118 (Perjury by Declaration) were charged and found as follows:

(A) Count 42 - On or about March 2, 1981, respondent testified, declared, deposed, and certified under penalty of perjury before the Board of Medical Quality Assurance in respondent's Petition for Modification of Probation (referenced in paragraph 47 supra), and in giving that declaration and/or testimony, he willfully stated as true material matter which he knew to be false, to wit: (1) that he was Board Eligible in obstetrics-Gynecology, (2) that he had not been disciplined by any hospital or health facility for a medical cause or reason since the effective date of the Board's most recent disciplinary action against him, (3) that his only post-graduate training was at De Paul Hospital in Norfolk, Virginia in 1970-71 and at Kings

County Hospital in Brooklyn, New York in 1971-74, and (4) that the "only hospital in area is deniing [sic] my privileges because I cannot prescribed class II and III drugs."

(B) Count 43 - On or about September 5, 1982, respondent testified, declared, deposed, and certified under penalty of perjury before the Board of Medical Quality Assurance in respondent's Petition for Termination of Probation (referenced in paragraph 47 supra), and in giving that testimony and/or declaration, he willfully stated as true material matter which he knew to b false, to wit: (1) that he was Board Eligible in Obstetrics-Gynecology, (2) that he had not been disciplined by any hospital or health facility for a medical cause or reason since the effective date of the Board's most recent disciplinary action against him, (3) that the reason he was unsuccessful in getting on staff at Valley Vista Hospital was that his medical license was on probation, and (4) that his only post-graduate training was at Kings County Hospital in Brooklyn, New York in 197174.

Said convictions are now final.

17

In addition to criminal conduct the conduct set forth in Finding 8(A), and each count therein, does constitute gross negligence.

18

In addition to criminal conduct, the conduct set forth in Finding 8(A), does constitute repeated negligent acts.

19

In addition to criminal conduct the conduct set forth in Finding 8(A), and each count therein, does constitute incompetence.

DETERMINATION OF ISSUES

I

Cause does exist for discipline of respondent's license pursuant to Business and Professions Code (BPC) sections 2256 and 490 separately and severally for each criminal count set forth in Finding 8 by reason of Findings 8 and 9.

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II

Separate cause does exist for discipline, pursuant to BPC section 2234 for specific violations as follows:

Section 2234(a) by reason of Finding 17.
Section 2234(b) by reason of Finding 18.
Section 2234(c) by reason of Finding 19.

III

(A) The history of this case is the history of a regulatory system gone awry. Respondent was originally disciplined as set forth in Finding 3 (1980). After serving but three years of a five year probation his license was fully restored by the Board in 1983. Respondent acting under his full license, then and there, as evidenced by the trail of infant deaths, constituted a clear and present danger to the public in general and to his patients in particular.

The first death occurred in 1982. The Board did not then, legally, act. Deaths thereafter occurred at the following rate with the following Board inaction:

Year	Deaths	Board Response
1983	2	No accusation on file with O.A.H.
1984	4	No accusation on file with O.A.H.
1985	1	No accusation on file with O.A.H.
1986	1	After passage of three and one-half years and 9 deaths accusation on file with O.A.H.

(B) Because the conduct was such that it included and far exceeded incompetence and gross negligence the criminal justice system - a system of punishment - was properly put in motion resulting, inter alia, in nine separate convictions of second degree murder. A lay jury of twelve in 1990 did that (after the Courts' preliminary injunction in 1988) which the regulatory system of discipline failed to do in prior years, to wit: stop respondent, colloquially, from killing infants.

(C) That respondent represented a danger to his patients and knew he represented same can be reasonably inferred from certain dicta of the Court in People v. Klvana, supra:

> ...Dr. Oakes stated that Klvana's experiences during his Downstate and Loma Linda residencies, as well as his repeated loss of hospital privileges and warning by other physicians served notice on Klvana that "he had difficulty in judgment-making, particularly regarding the management of obstetric patients." Dr. Oakes indicated it was impossible to believe that Klvana was not aware of the risks he was disregarding.
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> - - -
>
> Klvana asserts insufficient evidence was presented to support the second degree murder convictions. Specifically, Klvana argues "the only reasonable inference to be drawn from the overwhelming evidence of [Klvana's] technical incompetence and abject lack of medical judgment spanning the better part of seven years before the first death and all the attendant circumstances spanning the eleven year period beginning with [Klvana's downstate] residency and culminating with the [L[redacted]] death was that [Klvana] simply did not appreciate the life-threatening risks involved and/or his responses were an 'extreme departure' from the prevailing standards of care. . . . To find otherwise would be to sustain [Klvana's] second degree murder convictions on assumptions by an objective standard, not [on] substantial evidence of his subjective awareness and conscious disregard of the life-threatening dangers." (Italics omitted.) While this is an appropriate argument to make to a jury, and indeed was made to the jury in this case, it is inappropriate to ask an appellate court to reweigh the evidence and draw inferences which were rejected by the jury. (People v. Protopappas (1988) 20a Cal.App.3d 152, 168 [246 Cal.Rptr. 915]; People v. Summers (1983) 147 Cal.App.3d 180, 183-184 [195 Cal-Rptr. 21]. After reviewing the evidence presented at trial, we conclude sufficient evidence was presented from which the jury could reasonably infer that **Klvana was subjectively aware his methods of home and office deliveries were life endangering, but consciously and deliberately disregarded these risks.** (Emphasis by Administrative Law Judge)

By reason of the foregoing combined with the whole of the Findings herein it is here determined logically and legally that respondent proceeded and continued to proceed with births knowing he lacked the medical skill to perform them safely.

Despite that knowledge he knowingly subjected his patients to risk of death. That risk became reality and one

foreseeable and preventable death followed another. Yet respondent continued his "practice", without change, until the intervention of the Courts and the criminal justice system.

IV

The objective of an administrative proceeding relating to discipline, if any, is to protect the public; to determine whether a license holder has exercised his privilege in derogation of the public interest. Such proceedings are not for the primary purpose of punishment Camacho v. Youde (1979) 95 Cal.App.3d 161, 165; Ex Parte Brounsell (1778) 2 Cowp. 829, 98 Eng. Rep. 1385. The criminal justice system - the system of punishment - has extracted same from respondent.[6] To protect the public interest respondent's license to practice medicine must, if belatedly, be revoked.

ORDER

Respondent's license is hereby revoked.

DATED: 17 September 1993

RICHARD J. LOPEZ
Administrative Law Judge
Office of Administrative Hearings

RJL:mh

[6]Respondent is now incarcerated and will be for sometime.

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BEFORE THE
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In the Matter of the Accusation Against:	NO. D-3572
MILOS KLVANA, M.D. 24456 1/2 Lyons Avenue Newhall, CA 91321	ACCUSATION
Physician and Surgeon Certificate No. A29719,	
Respondent.	

Complainant, Kenneth J. Wagstaff, alleges that:

1. He is Executive Director of the Board of Medical Quality Assurance of the State of California (hereinafter the "board"), and brings this accusation solely in his official capacity.

2. On October 31, 1975, respondent Milos Klvana, M.D. (hereinafter "respondent"), was issued physician and surgeon certificate No. A29719 by the board. On October 13, 1978, an accusation was filed against respondent. On March 14, 1980, a decision became effective which revoked respondent's certificate

but stayed the revocation and placed respondent on five (5) years probation. On March 3, 1983, a petition to terminate probation was granted. Certificate No. A29719 is currently, and was at all times mentioned herein, in full force.

3. Business and Professions Code sections 2003 and 2004 provide, in pertinent part, that there is a Division of Medical Quality within the Board of Medical Quality Assurance, responsible for the enforcement of the disciplinary provisions of the Medical Practice Act (Chapter 5 of Division 2 of the Business and Professions Code); the administration and hearing of disciplinary actions appropriate to findings made by a medical quality review committee, the division, or an administrative law judge; and the suspension, revocation, or the imposition of limitations on certificates after the conclusion of disciplinary actions.

4. Business and Professions Code sections 2220, 2227 and 2234 authorize the Division of Medical Quality to suspend or revoke a physician's and surgeon's certificate or take other disciplinary action against a certificate holder who is guilty of unprofessional conduct.

5. Business and Professions Code section 2234, subdivision (a), provides that violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiracy to violate, any provision of the Medical Practice Act, is unprofessional conduct.

6. Business and Professions Code section 2234, subdivision (b), provides that gross negligence is unprofessional

conduct.

7. Business and Professions Code section 2234, subdivision (c), provides that performance of repeated negligent acts constitutes unprofessional conduct.

8. Business and Professions Code section 2234, subdivision (d), provides that incompetence is unprofessional conduct.

9. Business and Professions Code section 2262 states that altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record with fraudulent intent, constitutes unprofessional conduct.

In addition to any other disciplinary action, the Division of Medical Quality may impose a civil penalty of five hundred dollars ($500) for violation of section 2262.

10. Business and Professions Code section 2261 states that knowingly making or signing any certificate or other document related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

11. Business and Professions Code section 810, subdivision (a) states that it is unprofessional conduct and cause for license suspension or revocation for a health care professional to:

"(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

"(2) Knowingly prepare, make or subscribe any writing with intent to present or use the same, or allow

it to be presented or used in support of any such claim."

12. Business and Professions Code section 2234, subdivision (e), provides that the commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon is unprofessional conduct.

13. Business and Professions Code section 2264 states that the employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice, constitutes unprofessional conduct.

14. At all times relevant hereto respondent's medical offices were located at 5644 N. Rosemead Boulevard, Temple City, California and 24456 1/2 Lyons Avenue, Newhall, California.

15. Respondent is subject to discipline for violation of section 2234, subdivision (b), in that he has been guilty of gross negligence. The facts and circumstances are as follows:

A. Patient Catherine B.[1/]

(1) On or about January 30, 1981 respondent commenced the medical care of Catherine B., a thirty-three year old female with a pregnancy of greater than three months' duration, desiring an abortion.

---

1. The full names of patients referenced herein are available to respondent upon request for discovery.

Catherine B. had a history of anemia.

(2) Respondent did not obtain a medical history from Catherine B. and did not perform pre-operative blood work or any other laboratory testing.

(3) Catherine B. had an adverse anaesthetic reaction prior to the commencement of the abortion.

(4) Respondent performed Catherine B.'s abortion in his office and without using cervical laminaria.

(5) Respondent was contacted on January 31, 1981 and advised that Catherine B. had bleeding, pain, and a fever of 101°. Respondent prescribed an oral antibiotic without examining Catherine B.

(6) On February 1, 1981 respondent was advised that Catherine B. had taken the prescribed antibiotics and that her temperature was 103°. Respondent advised Catherine B. to come to his office for evaluation approximately twenty four hours later.

(7) On February 1, 1981 Catherine B. was admitted to Henry Mayo Hospital where septicemia and retained tissue were diagnosed.

(8) Respondent was grossly negligent in the medical care and treatment of Catherine B. in that:

(a) Respondent did not take a medical history nor perform blood work prior to performing an abortion on Catherine B.

(b) Respondent performed an office abortion on Catherine B. notwithstanding Catherine B.'s

second trimester pregnancy and adverse anaesthetic reaction.

(c) Respondent performed a second trimester abortion on Catherine B. without using cervical laminaria.

(d) Respondent did not immediately evaluate Catherine B.'s post-abortal infection.

(e) Respondent did not perform curettage on Catherine B.'s post abortal infection and retained products of conception.

B. Patient Mira G.

(1) On or about May 25, 1982 respondent commenced the medical care and treatment of Mira G., a thirty five year old RH negative female, twelve to thirteen weeks pregnant, with a history of previous live delivery, and an estimated date of confinement (labor and delivery) of December 5, 1982, desiring a home birth.

(2) Respondent failed to respond appropriately to Mira G.'s RH negative condition throughout Mira G.'s pre-natal and post-natal course.

(3) On November 9, 1982, at approximately 4 a.m., Mira G. ruptured her membranes, with light meconium appearing in the fluid. At approximately 9 a.m., on November 9, 1982, Mira G. went into active labor. She delivered a female infant, Samara, after 10 p.m., with significant meconium. Upon respondent's instruction, Linda Pellegrin, an unlicensed employee of respondent, attended at Mira G.'s labor at Mira G.'s home.

(4) Respondent was grossly negligent in the medical care and treatment of Mira G. in that:

(a) Respondent did not evaluate nor manage Mira G.'s RH negative condition throughout Mira G.'s pre-natal and post-natal course.

(b) Respondent failed to have Mira G. hospitalized for her pre-term (36-week) labor and delivery.

(c) Respondent delegated Mira G.'s care to Linda Pellegrin, his unlicensed employee.

(d) Respondent abandoned Mira G.

C. Patient Samara G.

(1) Samara G., a preterm (36 week) infant was delivered in her parent's home by an unlicensed employee of respondent, Linda Pellegrin, on November 9, 1982. Samara G. had an APGAR of 5 at one minute and of 6 at five minutes, with poor color, poor muscle tone, and poor reflexes.

(2) Samara G. had an initial respiratory rate of 70, and began grunting. Samara G.'s signs of respiratory distress were reported to respondent who refused to evaluate Samara G., but instead advised his unlicensed employee, Linda Pellegrin, to obtain oxygen to administer to Samara G.

(3) Respondent was again contacted about Samara G.'s condition and again refused to evaluate her.

(4) Samara G. suffered cardiac arrest shortly thereafter, approximately two hours after delivery, and

was subsequently pronounced dead at the emergency room of Henry Mayo Hospital.

(5) Respondent was grossly negligent in the medical care and treatment of Samara G. in that:

(a) Respondent failed to respond appropriately to the RH incompatibility between Samara G. and her mother, Mira G.

(b) Respondent failed to have Samara G.'s preterm birth take place in a hospital.

(c) Respondent delegated Samara G.'s care to Linda Pellegrin, an unlicensed employee of respondent.

(d) Respondent twice refused to evaluate Samara G.

(e) Respondent failed to have Samara G. immediately transferred to a hospital following birth.

(f) Respondent attempted to have Samara G.'s respiratory distress treated by administration of oxygen.

(g) Respondent abandoned Samara G.

D. Patient Kathie J.

(1) On or about July 19, 1982, respondent commenced the care and treatment of Kathie J., a twenty four year old pregnant female, with an estimated date of confinement of December 10, 1982, who had previously delivered two infants by caesarean section, and who desired natural childbirth. On December 23, 1982, Kathie J. commenced labor and was examined by respondent at his Newhall office.

(2) On December 24, 1982, Kathie J. was seen by respondent at his Newhall office, where respondent conducted an internal examination of Kathie J. using an ungloved hand.

(3) On December 24, 1982 respondent administered an oxytocic agent to Kathie J. intravenously to augment labor. Kathie J. then delivered a female infant, Amy J.

(4) Respondent was grossly negligent in his medical care and treatment of Kathie J. in that:

(a) Respondent delivered Kathie J. in his office notwithstanding the fact that she was not a suitable candidate for out-of-hospital birth due to two previous caesarean sections.

(b) Respondent conducted an internal examination of Kathie J. with an ungloved hand.

(c) Respondent augmented Kathie J's labor with intravenous administration of an oxytocic agent at respondent's office, which office was not equipped for oxytocic agent administration prior to birth.

(d) Respondent's office was not equipped for care and emergency treatment of a neonate.

E. Patient Amy J.

(1) Prior to and at Amy J's birth, on December 24, 1982, respondent stated that he would be responsible for Amy J's pediatric care. Respondent discharged Amy J. to go home with her parents within twenty five minutes

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after her birth, and advised her parents against taking her to a hospital for examination, notwithstanding Amy J.'s poor color, poor respiration, poor muscle tone, and poor reflexes. Amy J. did not cry after delivery or at anytime at respondent's office.

(2) On December 25, 1982, Amy J., one day old, was observed by her parents to have difficulty breathing to exhibit some seizure-like activity, and to refuse to nurse. Her parents placed calls to respondent, who returned them several hours later. Kathie J., Amy J.'s mother, informed respondent that Amy J. refused to nurse and had difficulty breathing. Respondent told Kathie J. that Amy J. probably had low blood sugar, discouraged her from taking Amy J. to a hospital, and instructed Kathie J. to treat Amy J. at home by administering sugar water orally.

(3) Later on December 25, 1982, Amy J. was observed to be purple and not to be breathing. Her parents immediately administered cardiopulmonary resuscitation and summoned paramedic assistance. Amy J. was transported by ambulance to Holy Cross Hospital where she was pronounced dead within an hour.

(4) Respondent was grossly negligent in his medical care and treatment of Amy J. in that he declined to examine her and discouraged her parents from taking her to a hospital for examination.

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F. Patient Jacqueline A.

(1) On or about July 1983, respondent commenced medical care and treatment of Jacqueline A., a twenty nine year-old pregnant woman, thirty one weeks pregnant, with an estimated date of confinement of August 24, 1983, seeking natural chilbirth at home.

(2) Jacqueline A. received prenatal care and treatment at respondent's office, with respondent's knowledge, from Delores Doyle, an unlicensed person. The agreement between respondent, Delores Doyle, and Jacqueline A. was that Delores Doyle would deliver Jacqueline A's infant at Jacqueline A's home, with respondent functioning as a "back up."

(3) Jacqueline A. was ill throughout the last three months of the pregnancy, experiencing labor pains without dilation, and demonstrating marked edema. On June 25, 1983, at 32 weeks gestation, Jacqueline A. had a fundal height of 37 cms. On August 22, 1983, at 40 weeks gestation, Jacqueline A.'s diastolic blood pressure was 80. Her baseline diastolic blood pressure was 60.

(4) Jacqueline A. lost approximately one cup of a mucousy, green discharge at one and one half weeks after her due date.

(5) On September 7, 1983, Jacqueline A. was post-mature with a 72 pound documented weight gain during her pregnancy by her 40th week.

(6) On September 11, 1983, Jacqueline A. was hemmorrhaging.

(7) On September 11, 1983, fetal heart tones of Jacqueline A.'s infant were imperceptible, and Jacqueline registered a blood pressure of at least 130/90.

(8) On September 12, 1983, respondent administered an intravenous oxytocic agent for induction of Jacqueline A.'s labor, first at his Temple City office. Respondent then had Jacqueline A.'s husband, Joseph A., transport Jacqueline A. home in the family car, with Jacqueline A. still hooked up to the IV oxytocin. At Jacqueline A.'s home the IV was again turned on. Jaqueline A. went immediately into strong labor, and then delievered a dead female infant, Tanya A., at home.

(9) Respondent was grossly negligent in the medical care and treatment of Jacqueline A. in that:

(a) Respondent failed to conduct medically required examinations and tests throughout the course of Jacqueline A's pregnancy.

(b) Respondent failed to diagnose signs of preeclampsia and maternal diabetes.

(c) Respondent delegated Jacqueline A's prenatal care and delivery to an unlicensed person, Delores Doyle.

(d) Respondent failed to respond appropriately when Jacqueline A.'s pregnancy became past-term.

(e) Respondent failed to perform his own assessment as to whether Jacqueline A. carried a live or dead fetus, and instead relied on the opinion of his unlicensed employee, Delores Doyle, that the fetus was dead.

(f) Respondent administered an oxytocic agent intravenously to Jacqueline A. at respondent's office, had Jacqueline A. transported in a car while still hooked up to the intravenous oxytocic agent, and administered an oxytocic agent intravenously to Jacqueline A. at her home.

(g) Respondent arranged for Jacqueline A. to deliver what was believed to be a dead fetus at Jacqueline A.'s home rather than in a hospital.

G. Patient Julie J.

(1) On or about August 1, 1983, respondent undertook the care and treatment of Julie J., a twenty one year old pregnant female, with an estimated date of confinement of October 14, 1984.

(2) On October 10, 1983, respondent administered an intravenous oxytocic agent to Julie J. at his Newhall office in an attempt to induce her labor.

(3) On October 12, 1983, respondent administered intravenous oxytocin to Julie J. in an attempt to augment her labor. The duration of the second stage of labor was three hours and forty five minutes. During the last hour and a half of labor, respondent applied

external abdominal pressure to promote descent of the fetus. Julie J. delivered infant Amanda H. on October 12, 1983, at approximately 1:15 p.m., at respondent's Newhall office.

(4) Julie J. suffered post-partum hemorrhage at respondent's office, for which respondent administered no treatment

(5) Respondent was grossly negligent in the medical care and treatment of Julie J. in that:

(a) Respondent failed to respond appropriately to Julie J.'s cephalopelvic disproportion.

(b) Respondent failed to respond appropriately to Julie J.'s prolonged labor.

(c) Respondent failed to respond appropriately to the abnormal presentation of Julie J.'s fetus.

(d) Respondent administered an oxytocic agent to Julie J. in his office, which office was not equipped for administration of oxytocic agents prior to birth.

H. Patient Amanda H.

(1) Respondent undertook the care and treatment of newborn Amanda H. at and following her delivery on October 12, 1983 at respondent's Newhall office. At birth Amanda H. had a detectable heartbeat but was not breathing. Respondent attempted to initiate Amanda H.'s breathing by pressing on her chest, giving mouth to

mouth resuscitation, and pouring warm water over her for approximately 20 minutes. He then declared her to be dead, a "fresh stillborn."

(2) Respondent was grossly negligent in the medical care and treatment of Amanda H. in that:

(a) Respondent allowed Amanda H.'s birth to take place vaginally at his office notwithstanding cephalopelvic disproportion, prolonged labor, and abnormal presentation during her delivery.

(b) Respondent attempted to effect Amanda H.'s birth by use of an oxytocic agent in his office, which office was not equipped for administration of oxytocic agents prior to birth.

(c) Respondent used primitive means to attempt to resuscitate Amanda H.

(d) Respondent failed to summon emergency assistance for Amanda H.

(e) Respondent's office was not equipped for care and emergency treatment of a neonate.

I. Patient Mira G. and Baby G.

(1) In or about July 1983 respondent undertook the medical care and treatment of Mira G., a thirty six year old RH negative female with a history of two live births and an estimated date of confinement of early January 1984, desiring a delivery in a "birth center."

(2) Throughout Mira G.'s pre-natal and post-natal course respondent failed to evaluate and manage her

RH negative condition.

(3) On or about January 16, 1984 Mira G. reported to respondent that her fetal movements had ceased. Respondent advised Mira G. to come to his office for evaluation the next day, and at that visit no fetal heart tones were detected.

(4) On or about January 17, 1984 respondent and his unlicensed employee, Jacqueline Leggett, delivered a stillborn of Mira G. at respondent's office.

(5) Respondent disposed of the stillborn infant in an unknown manner, destroyed records of the pregnancy and delivery, and failed to file birth and death certificates of the birth and death of the fetus.

(6) Respondent was grossly negligent in the medical care and treatment of Mira G. in that:

(a) Respondent failed to evaluate and manage Mira G.'s RH negative condition in her pre-natal and post-natal course.

(b) Respondent failed to respond appropriately to RH incompatibility between Mira G. and her fetus.

(c) Respondent failed to do non-stress testing to determine the fetus' condition when respondent became aware of cessation of fetal movements.

(d) Respondent failed to evaluate whether an emergency caesarean section would save Mira G.'s fetus.

(d) Respondent was assisted in the birth by an unlicensed person, Jacqueline Leggett.

(e) Respondent concealed the birth of the stillborn infant.

J. Patient Lanna D.

(1) On or about June 30, 1983 respondent commenced the medical care and treatment of Lanna D., a thirty-two year-old female, approximately seven weeks pregnant, with an estimated date of confinement of January 24, 1984, seeking natural childbirth at home.

(2) Lanna D. received prenatal care and treatment at respondent's office, with respondent's knowledge, from Delores Doyle, an unlicensed person. The agreement between respondent, Delores Doyle, and Lanna D. was that Delores Doyle would deliver Lanna D's infant at Lanna D's home, with respondent functioning as a "back up."

(3) Lanna D.'s hemoglobin dropped to 10.4 grams at 36 weeks' gestation.

(4) Lanna D. began labor in the morning of January 30, 1984, at approximately 3:30 a.m. At approximately 10 a.m. Delores Doyle, respondent's unlicensed employee, arrived at Lanna D.'s to manage the labor. At approximately 11:30 a.m., the fetus' heartbeat dropped and became sporadic and Delores Doyle made attempts to reposition the fetus. Lanna D's labor failed to progress and the fetus was in an abnormal

presentation. At approximately 4:30 p.m., respondent, who had been in telephone contact with Delores Doyle, ordered oxygen for Lanna D. The oxygen was brought to Lanna D.'s home by family members and administered to Lanna D. by Delores Doyle, who did not know how to use it.

(5) On January 30, 1984, at approximately 10 p.m., Lanna D. was transferred to respondent's Temple City office, where respondent administered an oxytocic agent to Lanna D. and delivered infant Aaron D. at approximately 11 p.m.

(6) Respondent was grossly negligent in the medical care and treatment of Lanna D. in that:

(a) Respondent failed to obtain past medical records of Lanna D. and to conduct evaluations throughout the course of Lanna D's pregnancy as to the suitability of Lanna D. for an out-of-hospital birth.

(b) Respondent delegated Lanna D's prenatal care and delivery to an unlicensed person, Delores Doyle.

(c) Respondent failed to treat Lanna D.'s decrease in hemoglobin at 36 weeks gestation and failed to evaluate her suitability for home birth at that time.

(d) Respondent failed to have Lanna D. hospitalized when Lanna D's labor became high risk.

(e) Respondent inadequately assessed Lanna D.'s suitability for out of hospital birth during her labor at respondent's office.

(f) Respondent administered oxytocin intravenously to Lanna D. at his office to augment Lana D.'s labor, which office was not properly equipped for administration of oxytocic agents prior to birth.

K. Patient Aaron D.

(1) Patient Aaron D. was born January 30, 1984, at respondent's Temple City medical office. At birth Aaron D. was blue, flaccid and non-breathing. Respondent and his unlicensed employee, Delores Doyle, attempted to resuscitate Aaron D. for three hours, administering cardio-pulmonary resuscitation, oxygen, and hot and cold baths.

(2) Shortly after Aaron D. finally began breathing, respondent sent Aaron and Aaron's parents home, giving the parents instructions to observe Aaron D. and to administer cardio-pulmonary resuscitation should he cease breathing. The parents had no prior experience or training in cardiopulmonary resuscitation.

(3) On January 31, 1984, at approximately 6 a.m., Aaron D. was found limp and unresponsive. Resuscitative efforts were made by his family members, and paramedic assistance was summoned. Paramedics transferred Aaron D. to Garden Grove Emergency Hospital, which transferred

him to Children's Hospital where it soon became apparent that Aaron was suffering from irreversible hypoxic brain damage. On February 7, 1984, life support systems were discontinued, and Aaron D. died.

(4) Respondent was grossly negligent in the medical care and treatment of Aaron D. in that:

(a) Respondent delegated the pre-natal and intra-partum care of Aaron D. to an unlicensed person.

(b) Respondent continued to delegate the intra-partum care of Aaron D. to his unlicensed employee, Delores Doyle, with knowledge that Aaron D. was suffering fetal distress.

(c) Respondent failed to summon emergency assistance for Aaron D. when the infant was born.

(d) Respondent employed primitive methods to attempt to resuscitate Aaron D.

(e) Respondent failed to summon emergency assistance for Aaron D. during an extensive resuscitation period.

(f) Respondent failed to maintain Aaron D.'s body temperature.

(g) Respondent had Aaron D. delivered in his office, which office was not equipped for care and emergency treatment of a neonate.

(h) Respondent discharged Aaron D. to his parents instead of hospitalizing him.

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K. Patient Kim E.

(1) In or about December 1983 respondent commenced the medical care and treatment of Kim E., a nineteen year old pregnant female in her first pregnancy, with an estimated date of confinement of May 25, 1984, desiring an office birth.

(2) Throughout the course of her pregnancy Kim E. received prenatal care from respondent at respondent's Temple City office. Delores Doyle, an unlicensed employee of respondent, assisted at the prenatal examinations.

(3) On May 19, 1984, Kim E. telephoned Delores Doyle from Kim E.'s home in Compton to notify respondent that she was in labor and would be coming to the clinic. Kim E. arrived at the clinic at approximately 3 p.m. and Delores Doyle, respondent's unlicensed employee, arrived shortly thereafter.

(4) At approximately 3:30 p.m. Delores Doyle performed an internal examination on Kim E. and informed Kim E. that respondent was en route.

(5) At approximately 6 p.m., Kim E.'s water broke and showed significant meconium.

(6) At approximately 8:30 p.m., Kim E. delivered infant Tyrone E. at respondent's office. Respondent arrived minutes before the delivery, but delegated the delivery to Delores Doyle, his unlicensed employee.

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(7) Respondent was grossly negligent in the medical care and treatment of Kim E. in that:

(a) Respondent abandoned Kim E.'s labor management to Delores Doyle, respondent's unlicensed employee.

(b) Respondent failed to assess whether or not Kim E. required emergency care at the time she showed significant meconium.

(c) Respondent failed to have Kim E. hospitalized for labor and delivery when meconium was observed after the rupture of Kim E.'s membranes.

(d) Respondent delegated Kim E.'s delivery to Delores Doyle, an unlicensed employee of respondent.

M. Patient Tyrone E.

(1) Tyrone E. was delivered at approximately 8:30 p.m. on May 19, 1985, at respondent's office. At Tyrone E.'s delivery meconium was present, including meconium at the area of the oral pharynx. Tyrone E.'s cry was muffled when he was born, and he sounded as if something was caught in his throat.

(2) No suctioning was performed on Tyrone E. prior to or near his first respiration.

(3) Respondent and Delores Doyle employed primitive means to attempt to suction meconium from Tyrone E. and did so for approximately forty five minutes.

(4) At Approximately 10:45 p.m., respondent, Delores Doyle, Mr. and Mrs. E., and Tyrone E. drove to the offices of pediatrician Paul Fleiss, M.D., to have Tyrone E. examined. Dr. Fleiss arranged for the immediate admission of Tyrone E. to Children's Hospital, where Tyrone E. was admitted for meconium aspiration. Tyrone E. died May 26, 1984 of respiratory failure secondary to meconium aspiration.

(5) Respondent was grossly negligent in the medical care and treatment of Tyrone E. in that:

(a) Respondent delegated the intra-partum care of Tyrone E. to Delores Doyle, an unlicensed person.

(b) Respondent delegated the delivery of Tyrone E. to Delores Doyle, an unlicensed person.

(c) Respondent failed to suction Tyrone E. of meconium at the necessary time.

(d) Respondent failed to suction Tyrone E. of meconium in the necessary manner.

(e) Respondent failed to summon emergency assistance for Tyrone E. immediately after Tyrone E.'s birth.

(f) Respondent further delayed Tyrone E.'s receiving necessary medical care in that after a prolonged period of resuscitation respondent had Tyrone E. taken by car caravan to a pediatrician's office rather than arranging for emergency

transport of Tyrone E. to a hospital.

N. Patient Jeanette H.

(1) In or about October 1983, respondent commenced the care and treatment of Jeannette H. a twenty year old pregnant female with an estimated date of confinement of May 10, 1984, desiring an office birth.

(2) On or about May 28, 1984, at approximately 4:35 a.m. Jeanette H. delivered a male infant in respondent's Newhall office. Respondent repaired Jeanette H.'s third degree perineal laceration with three locking sutures which continued to bleed following this attempted repair. Respondent then left the office at approximately 5 a.m.

(3) On or about May 18, 1984 Donald H., Jeanette H.'s husband, attempted to contact respondent from approximately 11 a.m. to 10 p.m. due to Jeanette H.'s continued bleeding. At approximately 10 p.m. Jeanette H. received emergency treatment for her perineal laceration at Henry Mayo Newhall Hospital.

(4) Respondent was grossly negligent in the medical care and treatment of Jeanette H. in attempting to repair her third degree perineal laceration with three locking sutures, leaving the laceration mal-aligned, uneven, gaping, and bleeding.

O. Patient Virginia N.

(1) On or about November 2, 1983, respondent commenced the care and treatment of Virginia N. a twenty

five year old pregnant female with an estimated date of confinement of June 15, 1984.

(2) Virginia N. had a history of breech delivery, and on April 11, 1984 Virginia N.'s sonogram showed the fetus she was carrying to be in breech position. On June 29, 1984, respondent delivered Virginia N.'s infant, a breech delivery, at respondent's Temple City office.

(3) Respondent was grossly negligent in the medical care and treatment of Virginia N. in not noting the presentation of the fetus pre-natally, in not noting the presentation of the fetus at the onset of labor, and in delivering Virginia N.'s infant at respondent's office instead of in a hospital.

P. Patient Deborah F.

(1) On or about April 7, 1983, respondent commenced care and treatment at his Newhall offices of Deborah F., a nineteen year old pregnant female, in her first pregnancy, whom respondent delivered of a surviving infant.

(2) Deborah F. was attended by respondent in what he reported to be a second pregnancy which terminated by spontaneous abortion. Respondent performed a curretage following the spontaneous abortion.

(3) Deborah F. subsequently developed diabetes mellitis, for which she was admitted to Henry Mayo Newhall Memorial Hospital on November 25, 1983. After

her release, Deborah F. was placed on NPHU 100, Insulin, 35 units daily by injection. The week after her discharge from Henry Mayo Hospital, Deborah F. had an examination by respondent. Deborah F. informed respondent that she was an insulin dependent diabetic.

In or about February 1984, respondent informed Deborah F. that she was pregnant, with an estimated date of confinement of October 11, 1984. Respondent then commenced the care and treatment of this third pregnancy.

(4) In her third pregnancy, on August 29, 1984, at approximately 9 p.m., Deborah F. started gentle labor pains. She arrived at respondent's office on August 30, 1984, at approximately 8:30 a.m. Respondent examined Deborah F. at that time and informed her that she was in labor. At approximately 12:30 p.m., on August 30, 1984, Deborah F. delivered Jason F. at respondent's Newhall office.

(4) Respondent was grossly negligent in the medical care and treatment of Deborah F. in that:

(a) Respondent failed to obtain historical and physical examination information during Deborah F.'s second pregnancy.

(b) Respondent failed to do a histological evaluation of the tissues obtained as a result of his curretage of Deborah F. to determine whether, in fact, Deborah F. had a second pregnancy which was aborted, or whether her symptoms were due to

some other cause.

(c) Respondent failed to obtain historical and physical examination information during Deborah F.'s third pregnancy, and failed to do necessary tests.

(d) Respondent failed to follow up on glucose spills in Deborah F.'s urine during Debora F.'s third pregnancy, notwithstanding the fact that Deborah F. was a high risk obstetrical patient due to her insulin dependent diabetes.

(f) Respondent failed to prevent the progress of Deborah F.'s 34 week premature labor in Deborah F.'s third pregnancy.

(g) Respondent abandoned Deborah F. during Deborah F.'s third pregnancy to respondent's unlicensed employee, Jacqueline Leggett, while Deborah F. was in labor at respondent's office.

(h) Respondent managed the delivery of Deborah F. at his office rather than a hospital notwithstanding the fact that Deborah F. was a high risk patient due to both insulin dependent diabetes and premature labor.

Q. Patient Jason F.

(1) Respondent commenced the care and treatment of premature infant Jason F. following Jason F.'s birth on August 30, 1984. At birth, patient Jason F. was purple, listless, and demonstrated difficulty breathing. Jason F. was discharged by respondent to his parent's home,

where at 4:45 a.m., he was found not to be breathing. Jason F.'s father attempted to administer mouth to mouth resuscitation, and Deborah F. immediately called paramedics. The paramedics immediately transported Jason F. to Henry Mayo Hospital, were Jason F. was treated and pronounced dead.

(2) Respondent was grossly negligent in the medical care and treatment of Jason F. as follows:

(a) Respondent delivered Jason F. in his office notwithstanding the fact that Jason F. was the premature infant of an insulin dependent diabetic mother.

(b) Respondent's office was not equipped for care and emergency treatment of a neonate.

(c) Respondent failed to have Jason F. immediately hospitalized after delivery.

(d) Respondent failed to summon emergency assistance for Jason F.

(e) Respondent discharged Jason F. home to his parents rather than having him transported to a hospital.

R. Patient Lisa F.

(1) On October 20, 1984, at 8 a.m., at the offices of the San Fernando Surgical Center, 1056A North Mc Clay Street, San Fernando, California, respondent commenced the care and treatment of Lisa F., a twenty six year old female, approximately fourteen weeks pregnant, desiring

an abortion. No pelvic examination was conducted prior to the abortion.

(2) Lisa F. experienced burning pain in her stomach and uterus upon recovering from the anaesthesia. She reported the pain, but was not examined, and was discharged at 9:45 a.m.

(3) Lisa F. became increasingly ill, with pains in her stomach and appendix area and a temperature of 104°. She returned to the clinic, was given an injection to stimulate contractions, and sent home.

(4) After repeated calls to the clinic regarding Lisa F's increasing pain, respondent examined Lisa F. at 9 p.m. on October 20, 1984. Respondent administered Demerol to Lisa F., and gave a friend of Lisa F's, an unlicensed individual, more Demerol and syringes with which to administer it.

(5) At approximately 2 a.m., on October 21, 1984, respondent was informed that Lisa F. was still in extreme pain. At approximately 1 a.m., October 22, 1984, respondent admitted Lisa F. to East Los Angeles Doctors Hospital. An abdominal X-ray series of October 21, 984, revealed "free intraperitoneal air consistent with a perforated viscus."

(6) On October 24, 1984 an abdominal hysterectomy and appendectomy were performed on Lisa F. Lisa F. was discharged from East Los Angeles Doctors' Hospital on October 30, 1984. After discharge, respondent gave Talwin

and syringes to Lisa F's friend for administration to Lisa F.

(7) On or about November 5, 1984, respondent failed to evaluate why Lisa F. still required intramuscular analgesia for pain control, and abandoned Lisa F. as a patient.

(8) On or about November 8, 1984, Lisa F. was admitted to Granada Hills Hospital by a subsequent treating physician. She was diagnosed as having a rectovaginal fistula and intraabdominal adhesions and a colostomy was performed.

(9) Respondent was grossly negligent in the medical care and treatment of Lisa F. in that:

(a) Respondent conducted no pelvic examination prior to Lisa F.'s abortion.

(b) Respondent failed to evaluate Lisa F. on October 21, 1986.

(c) Respondent failed to recognize obvious signs that perforation of the uterus and bowel damage had occurred during the abortion, and did not hospitalize Lisa F. until October 22, 1984.

(d) Respondent gave injectable Demerol to Lisa F. rather than evaluating the cause of her pain, and respondent instructed an unlicensed friend of Lisa F.'s to administration the injections.

(e) Respondent abandoned Lisa F. on November 5, 1984 and failed to evaluate why she continued to experience severe pain.

S. Patient Nancy H.

(1) In or about September 1984 respondent commenced the care and treatment of Nancy H., a seventeen year old pregnant RH negative female with a previous live delivery and an estimated date of confinement of April 29, 1985.

(2) On March 31, 1985, Nancy H. began labor and reported the onset of labor to respondent. On April 1, 1985, at approximately 9:30 a.m., respondent administered an oxytocic agent to Nancy H. at his Newhall office. Nancy H. delivered a female infant, Alicia H., approximately 10:45 a.m., April 1, 1985.

(3) Respondent was grossly negligent in the medical care and treatment of Nancy H. in that:

(a) Respondent failed to respond appropriately to Nancy H.'s RH negative condition throughout Nancy H.'s pre-natal and post-natal course.

(b) Respondent failed to prevent Nancy H.'s pre-term delivery.

(c) Respondent administered an oxytocic agent to Nancy H. in an attempt to augment what he knew to be pre-term labor.

(d) Respondent administered an oxytocic agent to Nancy H. in his office, which office was not equipped for administration of oxytocin prior to birth.

(e) Respondent conducted the pre-term delivery in his office rather than in a hospital.

T. Patient Alicia H.

(1) Respondent commenced the care and treatment of premature newborn Alicia H. at her birth on April 1, 1985 at approximately 10:45 a.m.

(2) Alicia H. was purple and did not cry at birth. Respondent placed Alicia H. in a tub of water and cleaned the mucous from her throat until she started crying. At that time she was gasping for air.

(3) At 12:30 a.m., respondent discharged Alicia H. to her parents. At 1 p.m. Alicia H. turned very purple and evidenced difficulty breathing. She was seen at the emergency room at Henry Mayo Newhall Hospital, given emergency care, and transferred by ambulance to the neonatal intensive care unit at Valley Presbyterian Hospital.

(4) Respondent was grossly negligent in his medical care and treatment of Alicia H. in that:

(a) Respondent failed to prevent Alicia H.'s preterm delivery.

(b) Respondent conducted Alicia H.'s pre-term delivery in his office rather than in a hospital.

(c) Respondent's office was not equipped for care and emergency treatment of a neonate.

(d) Respondent did not have Alica H. hospitalized immediately after birth.

U. Patient Lorraine A.

(1) On or about January 10, 1985, respondent commenced the care and treatment of Lorraine A., a

sixteen year old RH negative female, nineteen weeks pregnant, with an estimated date of confinement of June 11, 1985, and a previous pregnancy.

(2) Lorraine A. received pre-natal care and treatment from respondent and also received pre-natal care and treatment at respondent's office and with respondent's knowledge from Delores Doyle, an unlicensed person.

(3) On or about May 9, 1985 respondent abandoned Lorraine A's prenatal care and delivery to Delores Doyle.

(3) On June 17, 1985, after a twenty-four hour labor, Lorraine A. gave birth at home, attended by Delores Doyle. Respondent arrived shortly after the birth, and in attempting to remove the placenta respondent inserted an ungloved hand into Lorraine A.. In the process of delivering Lorraine A.'s placenta her uterine wall became inverted. Respondent attempted to manually revert the uterus.

(4) When Lorraine A hemmorrhaged and was in shock, respondent advised against calling for emergency assistance, and refused to accompany Lorraine A. to San Gabriel Hospital. At San Gabriel Hospital, Lorraine A. was treated for shock, inverted uterus, hemorrhage, hypovolemia, and cervical laceration.

(5) Respondent was grossly negligent in the medical care and treatment of Lorraine A. in that:

(a) Respondent abandoned Lorraine A. and delegated Lorraine A's prenatal care and delivery to an unlicensed person, Delores Doyle.

(b) Respondent failed to evaluate Lorraine A.'s RH negative condition throughout her pre-natal course.

(c) Respondent inserted an ungloved hand into Lorraine A's vagina immediately following Lorraine A.'s delivery.

(d) Respondent reverted Lorraine A.'s uterus into her vagina.

(e) Respondent failed to immediately summon emergency aid and hospital transport for Lorraine A.

(f) Respondent advised against summoning emergency aid and/or hospitalizing Lorraine A.

(g) Respondent abandoned Lorraine A. while she was experiencing a critical medical emergency.

(h) Respondent failed to convey necessary information regarding Lorraine A. to hospital personnel.

16. Respondent is further subject to discipline for violation of Business and Professions Code section 2234, subdivision (d), in that he has been guilty of incompetence, based on the facts and circumstances set forth in paragraph 15, herein incorporated by reference as though fully set forth at this point.

17. Respondent is further subject to discipline for violation of Business and Professions Code section 2234, subdivision (c), in that he has been guilty of repeated negligent acts, based on the facts and circumstances set forth in paragraph 15, herein incorporated by reference as though fully set forth at this point.

18. Respondent is further subject to discipline for violation of Business and Professions Code section 2264, in that he has employed, directly and/or indirectly and aided and/or abetted unlicensed persons to engage in the practice of medicine and/or a mode of treating the sick or afflicted which requires a license to practice. The facts and circumstances are as follows:

A. Respondent aided and/or abetted and conspired with Delores Doyle, an unlicensed person, in Delores Doyle's prenatal and delivery care of patient Lana D., as set forth in paragraphs 15J, which is incorporated by reference herein as though fully set forth at this point.

B. Respondent aided and abetted and conspired with Delores Doyle, an unlicensed person, in Delores Doyle's prenatal care of patient Jacqueline A., as set forth in paragraph 15F, which is incorporated by reference herein as though fully set forth at this point.

C. Respondent aided and abetted and conspired with Delores Doyle, an unlicensed person, in Delores Doyle's prenatal and delivery care of Lorraine A., as set forth in paragraph 15U which is incorporated by reference herein as though fully set forth at this point.

D. Respondent aided and abetted and conspired with Delores Doyle's delivery care of Kim E., as set forth in paragraph 15K, which is incorporated by reference as though fully set forth at this point.

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E. Respondent aided and abetted and conspired with Linda Pellegrin, an unlicensed person, in Linda Pellegrin's delivery of Baby Samara G. by Mira G., as set forth in paragraphs 15B and 15C, which are incorported herein as though fully set forth at this point.

F. Respondent aided and abetted and conspired with Linda Pellegrin, an unlicensed person, in Linda Pellegrin's deliveries as follows:

(1) In the delivery of an infant by Laura B. on September 24, 1980.

(2) In the delivery of an infant by Jean F., on April 1, 1981.

(3) In the delivery of an infant by Susan F. on November 19, 1982.

(4) In the delivery of an infant by Marilyn G. on August 30, 1980.

(5) In the delivery of an infant by Beverly H. on June 4, 1982.

(6) In the delivery of an infant by Liane A. on February 6, 1984.

19. Respondent is further subject to discipline for violation of Business and Professions Code section 2262, in that he altered and/or modified the records of persons with fraudulent intent and/or created a false record with fraudulent intent, in his entries in the medical records of the following patients:

A. Lana D.

B. Kathie J.

C. Deborah F.

D. Kim E.

E. Tosha L.

20. Respondent is further subject to discipline for violation of Business and Professions Code section 2262, in that respondent knowingly made and/or signed a certificate related to the practice of medicine which falsely represented the existence or non-existence of a state of facts in that:

A. Respondent made and/or signed false insurance billings which included procedures which were never performed and/or which were performed by unlicensed associates of respondent, in his billings for the following patients:

(1) Lana D.

(2) Mira G.

(3) Kathy K.

(4) Roxanne L.

(5) Miriam L.

(6) Charlottte L.

(7) Stacy L.

(8) Susan M.

(9) Leigh P.

(10) Elizabeth R.

(11) Virginia S.

(12) Billie W.

(12) Nancy A.

(13) Janis B.

(14) Cindy H.

(15) Dominique B.

(16) Jacqueline B.

(17) Kim C.

(18) Ruby C.

(19) Sandi S.

(20) Marlene W.

(21) Linda H.

(22) Diane H.

(23) Evonne L.

(24) Janice P.

(25) Kim G.

(26) Sandra O.

(27) Terry M.

(28) Lori O.

(29) Marilyn G.

(30) Kathy B.

B. Respondent falsely declared under penalty of perjury that his license to practice medicine had never been subject to discipline in:

(1) Respondent's California application for supervision of physicians' assistants.

(2) In his application for privileges at Valley Vista Hospital.

C. Respondent falsely stated in his Board of Medical Quality Assurance Probationer Fact Sheets dated April 5, 1980, April 27, 1981, and March 24, 1982, and

in his Petition for Modification of Probation, dated March 2, 1981, and in his Petition for Termination of Probation, dated September 5, 1982, that he was board-eligible.

21. Respondent is further subject to discipline for violation of Business and Professions Code section 2234, subdivision (e) in that he committed acts involving dishonesty and/or corruption which are substantially related to the qualifications, functions, or duties of a physician and surgeon, based on the facts and circumstances set forth in paragraphs 19 and 20, herein incorporated by reference as though fully set forth at this point.

22. Respondent is further subject to discipline under Business and Professions Code section 2234, subdivision (e) in that:

A. On March 24, 1982, in a probation interview with a representative of the California Board of Medical Quality Assurance, respondent falsely stated that he had stopped doing out-of-hospital deliveries.

B. On September 20, 1984, in an interview with a representative of the California Board of Medical Quality Assurance, respondent falsely stated that he did not use oxytocin in his office and that he was ceasing practice of obstetrics and gynecology completely.

23. Respondent is further subject to discipline under Business and Professions Code section 810, subdivision (a) in that he knowingly presented false and/or fraudulent insurance

claims as set forth in paragraph 20A, which is incorporated by reference as though fully set forth at this point.

24. Respondent is further subject to discipline under Business and Professions Code section 2234, subdivision (a) in that he violated the Medical Practice Act and assisted, aided and abetted violations of the Medical Practice Act, and conspired to violate the Medical Practice Act as set forth in paragraphs 15 through 23, which are incorporated by reference herein as though fully set forth at this point.

WHEREFORE, complainant requests that the Division of Medical Quality hold a hearing on the matters alleged herein and that, following said hearing, the Division issue a decision.

1. Revoking or suspending physician's and surgeon's certificate number A 29719, heretofore issued to respondent Milos Klvana, M.D., and

2. Taking such other action as it deems proper.

DATED: November 3, 1986.

KENNETH J. WAGSTAFF
Executive Director
Board of Medical Quality Assurance
State of California

Complainant

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	NO. D-3572
MILOS KLVANA, M.D. 24456 1/2 Lyons Avenue Newhall, CA 91321 Physician and Surgeon Certificate No. A29719, Respondent.	NOTICE OF AMENDMENT TO ACCUSATION

TO THE RESPONDENT ABOVE NAMED:

PLEASE TAKE NOTICE that complainant Kenneth Nagstaff, by and through his attorneys Linda J. Vogel and Stephen S. Handin, Deputy Attorneys General, hereby amend the accusation heretofore filed therein as follows:

On page 27, line 16, "Jacqueline Leggett" is stricken, and "Shirley Wilson" is inserted in it's place, so that the paragraph reads as follows:

/

/

(c) Respondent abandoned Deborah F. during Deborah F.'s third pregnancy to respondent's unlicensed employee, Shirley Wilson, while Deborah F. was in labor at respondent's office.

DATED: November 4, 1986

JOHN K. VAN DE KAMP, Attorney General
LINDA J. VOGEL,
STEPHEN G. PANDIT,
Deputy Attorneys General

By: _____
LINDA J. VOGEL
Deputy Attorney General

Attorneys for Complainant

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REDACTED

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MILOS KLVANA, M.D. 24456-1/2 Lyons Avenue Newhall, CA 91321 Physician and Surgeon Certificate No. A29719, Respondent.	NO. D-3572 FIRST SUPPLEMENTAL ACCUSATION

Complainant, Kenneth J. Wagstaff, as further causes for discipline, alleges that:

25. He is Executive Director of the Board of Medical Quality Assurance of the State of California (hereinafter "the board"), and brings this first supplemental accusation solely in his official capacity.

26. Business and Professions Code section 2234, subdivision (a), provides that violating or attempting to violate, directly or indirectly, or assisting in or abetting the

violation of, or conspiracy to violate, any provision of the Medical Practice Act, is unprofessional conduct.

27. Business and Professions Code section 2234, subdivision (b) provides that gross negligence is unprofessional conduct.

28. Business and Professions Code section 2234, subdivision (c), provides that performance of repeated negligent acts constitutes unprofessional conduct.

29. Business and Professions Code section 2234, subdivision (d), provides that incompetence is unprofessional conduct.

30. Business and Professions Code section 2262 states that altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record with fraudulent intent, constitutes unprofessional conduct.

In addition to any other disciplinary action, the Division of Medical Quality may impose a civil penalty of five hundred dollars ($500) for violation of section 2262.

31. Business and Professions Code section 2261 states that knowingly making or signing any certificate or other document related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

32. Business and Professions Code section 810, subdivision (a), states that it is unprofessional conduct and cause for license suspension or revocation for a health care provider to:

"(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

"(2) Knowingly prepare, make or subscribe any writing with intent to present or use the same, or allow it to be presented or used in support of any such claim."

33. Business and Professions Code section 2234, subdivision (e), provides that the commission of any act of dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon is unprofessional conduct.

34. Business and Professions Code section 2264 states that the employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice, constitutes unprofessional conduct.

35. Business and Professions Code section 2238 provides that violation of any federal statute or federal regulation or of any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

36. 21 U.S.C. section 801 et. seq. provides that all practitioners who possess, dispense, or prescribe controlled substances must have a current registration issued by the United States Department of Justice Drug Enforcement Administration.

37. Respondent's license to practice medicine is subject to discipline for violation of Business and Professions Code section 2234, subdivision (b), in that he has been guilty of gross negligence. The facts and circumstances are as follows:

A. Patient Joanne F.[1]/

(1) On or about March 1983, respondent undertook the obstetrical care of Joanne F., a 34-year old woman approximately three months pregnant and desiring an out-of-hospital delivery. On August 23, 1983, at approximately 10:00 p.m., Joanne F.'s membranes ruptured and shortly thereafter she began experiencing uterine contractions. On August 25, 1983, at approximately 2:00 p.m., a stillborn infant was delivered of Joanne F. by respondent at his Newhall office.

(2) Respondent was grossly negligent in the medical care and treatment of Joanne F. in that:

(a) Respondent failed to properly evaluate Joanne F. and the fetus for cephalopelvic disproportion.

(b) Respondent failed to properly monitor and document the progress of the labor and delivery.

(c) Respondent failed to properly respond to the fact that the labor was protracted and the fetus remained undelivered more than

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1. The full names of patients referenced herein are available to respondent upon request for discovery.

24 hours following rupture of the membranes.

(d) Respondent allowed the application of excessive external fundal pressure by unqualified people.

(e) Respondent utilized intravenous oxytocin to augment labor in an out-of-hospital setting and without adequate fetal monitoring.

(f) Respondent disposed of the stillborn without preparing a death certificate and without seeking an autopsy to determine the cause of death.

(g) Respondent advised the parents to conceal the fact that the death occurred.

B. Patient Arleen P.

(1) On or about July 11, 1984, respondent undertook the obstetrical care of Arleen P., a 27-year old Rh-negative woman, approximately one month pregnant and desiring an out-of-hospital delivery. On February 28, 1985, at approximately 5:00 p.m., Arleen P.'s membranes ruptured, and at approximately 5:30 p.m. on the same date, Arleen P. went to respondent's Temple City office. On March 1, 1985, at approximately 8:00 p.m., Arleen P., not yet having given birth, left respondent's Temple City office and went to the Methodist Hospital of Southern California where later that night she delivered a stillborn infant.

(2) Respondent was grossly negligent in the medical

care and treatment of Arleen P. in that:

(a) Respondent failed to properly evaluate Arleen P. and the fetus for cephalopelvic disproportion and fetal presentation.

(b) Respondent failed to properly monitor and document the progress of Arleen P.'s labor.

(c) Respondent failed to properly respond to the fact that the labor was protracted and the fetus remained undelivered more than 24 hours following rupture of the membranes.

(d) Respondent failed to properly respond to Arleen P.'s symptoms of preeclampsia.

(e) Respondent failed to properly respond to the signs of fetal distress.

(f) Respondent utilized intravenous Pitocin to augment labor in an out-of-hospital setting and without adequate fetal monitoring.

(g) Respondent stopped and then resumed the Pitocin induction.

(h) Respondent failed to assess Arleen P's Rh-negative condition throughout her pregnancy.

C. Patient Shirley J.

(1) On or about July 9, 1983 respondent undertook the obstetrical care of Shirley J., a pregnant female with a history of chronic hypertension, two premature infants, and a pregnancy which was terminated due to extreme

hypertension. During the pregnancy Shirley J. showed symptoms of rising blood pressure. A sonogram showed that the fetus was in breech position and had signs of intrauterine growth retardation. On August 26, 1983, the fetus' heartbeat could not be detected. On August 28, 1983, Shirley J. experienced extreme and enduring pain, and later that day delivered a stillborn infant.

(2) Respondent was grossly negligent in the medical care and treatment of Shirley J. in that:

(a) Respondent aided and abetted Delores Doyle, an unlicensed person, in Doyle's provision of obstetrical care to Shirley J.

(b) Respondent failed to inform Shirley J. that hers was a high-risk pregnancy.

(c) Respondent failed to manage Shirley J.'s hypertension, and her pregnancy-induced extreme hypertension.

(d) Respondent abandoned Shirley J.

D. Patient Tosha L.

(1) On September 9, 1986 Tosha L., a pregnant woman whose prenatal care was being managed by Lucile Schober, a chiropractor associate of respondent's, experienced rupture of her membranes with evidence of meconium in the fluid. On September 10, 1986 respondent undertook the obstetrical care of Tosha L. at his Newhall office. Respondent administered Pitocin to Tosha L. for five hours, telling her that what he was administering was only vitamins and

minerals. During the administration of the Pitocin and consequent contractions, Tosha L. showed further meconium staining. Respondent advised Tosha L. that she had not made progress, and to return to his office two days later. Tosha L. returned to respondent's office later on September 10, 1986, was briefly evaluated by respondent, and told to leave. On September 12, 1986 Tosha L. returned to respondent's office where he administered Pitocin to her again, and he informed her again that what he was administering was only vitamins and minerals. The Pitocin was administered without regulation. Several hours later infant Regan L. was delivered.

(2) Respondent was grossly negligent in the medical care and treatment of Tosha L. in that:

(a) Respondent delegated her prenatal care to Lucile Schober, a chiropractor associate of his.

(b) Respondent failed to properly respond to Tosha L.'s prolonged rupture of the membranes.

(c) Respondent failed to properly respond to Tosha L.'s meconium staining.

(d) Respondent utilized intravenous Pitocin to augment labor in an out-of-hospital setting and without adequate fetal monitoring.

(e) Respondent lied to Tosha L. in informing her that he was administering vitamins and minerals when, in fact, he was administering an oxytocic agent.

(f) Respondent stopped and then resumed the Pitocin

administration.

(g) Respondent neglected Tosha L.'s labor for days.

(h) Respondent conducted Tosha L's delivery on an unchanged bed on which Tosha L. had discharged meconium-stained amniotic fluid two days previously.

(i) Respondent failed to evaluate and respondent appropriately to evidence of Tosha L.'s cephalopelvic disproportion.

(j) Respondent allowed chiropractor Lucile Schober to perform vaginal exams on Tosha L. during Tosha L.'s labor at respondent's office.

(k) Respondent allowed chiropractor Lucille Schober to push on Tosha L.'s abdomen in an attempt to push the infant out the birth canal.

(k) Respondent failed to diagnose and treat a cervical laceration which Tosha L. sustained during her delivery of infant Regan L.

(l) Respondent abandoned Tosha L. shortly after the delivery.

E. Patient Regan L.

(1) Infant Regan L. was delivered with evidence of extreme molding of her head. Shortly after her birth, respondent submerged her in cold water, then allowed her to remain several hours at his clinic. The following day Tosha L. suctioned from Regan L. what Tosha L. believed to be mucous. The next

morning infant Regan L. was discovered dead.

(2) Respondent was grossly negligent in his care of Regan L. in that:

(a) Respondent failed to properly suction Regan L.

(b) Respondent failed to monitor Regan L. throughout the administration of Pitocin to Tosha L.

(c) Respondent failed to respond properly to the evidence that Regan L. had suffered trauma during birth.

(d) Respondent failed to respond properly to the fact that Regan L. was at high risk of infection due to the prolonged rupture of Tosha L.'s membranes.

(e) Respondent submerged Regan L. in cold water following her birth.

(f) Respondent advised against Regan L. being seen by a physician the day after her birth.

(g) Respondent abandoned Regan L.'s care to chiropractor Lucile Schober.

F. Patient Shane W.

(1) On January 21, 1988 respondent undertook the medical care and treatment of Shane W., a female patient who patient who reported a late menses. Respondent took no family or individual history, performed no physical examination, performed no urinalysis other than a urine pregnancy test, and made no chart for Ms. W. Respondent dispensed to Ms. W. seven tablets, telling her to take one a day, without informing her what the tablets were. The

tablets were Loestrin, an estrogen-progesterone compound.

(2) Respondent was grossly negligent in his care of Shane W. in that:

(a) He took no family history before dispensing an estrogen-progesterone compound.

(b) He used an improper medication in an attempt to induce Shane W.'s menses.

(c) He performed no physical examination before dispensing an estrogen-progesterone compound to Shane W.

(d) He made no medical record of Shane W.'s diagnosis and treatment.

G. Respondent abandoned patient Virginia N. during her labor and delivery.

H. Respondent used his unlicensed associates, chiropractor Lucile Schober, and a physician's assistant student as his backup to handle deliveries and other medical emergencies in his absence.

38. Respondent's certificate to practice medicine is further subject to discipline for violation of Business and Professions Code section 2234, subdivision (d), in that he has been guilty of incompetence, based on the facts and circumstances set forth in paragraph 37, herein incorporated by reference as though fully set forth at this point.

39. Respondent's certificate to practice medicine is further subject to discipline for violation of Business and Professions Code section 2234, subdivision (c), in that he has

been guilty of repeated negligent acts, based on the facts and circumstances set forth in paragraph 37, herein incorporated by reference as though fully set forth at this point.

40. Respondent's certificate to practice medicine is further subject to discipline under Business and Professions Code section 2262 in that respondent altered and/or modified the records of persons with fraudulent intent and/or created a false record with fraudulent intent, in his entries in the medical records of the following patients:

A. Lorraine A.

B. Nancy H.

C. Polly F.

D. Arleen P.

E. Karen N.

F. Shirley J.

G. Joanne F.

H. Julie J.

I. Mira G.

J. Jacqueline A.

41. Respondent's certificate to practice medicine is further subject to discipline for violation of Business and Professions Code section 2261, in that respondent knowingly made and/or signed a certificate related to the practice of medicine which falsely represented the existence or non-existence of a state of facts in that:

A. The facts alleged in paragraph 40 are incorporated by reference as though fully set forth at this point.

B. Respondent omitted from documents filed with the Board of Medical Quality Assurance the fact that he had participated in a residency at Loma Linda University.

C. Respondent signed a birth certificate stating that he had delivered an infant from patient Virginia N. when, in fact, the delivery was conducted by respondent's unlicensed associate, Delores Doyle.

D. Respondent falsified the cause of death on the stillborn certificate of Tanya A.

E. Respondent made and/or signed false insurance billings which included procedures which were never performed and/or which were performed by unlicensed associates of respondent, in his billings for the following patients:

(1) Arleen P.

(2) Infant N.

(3) Tosha L.

(4) Karen N.

(5) Mary Kay G.

F. Respondent falsely represented his continuing education to the Board of Medical Quality Assurance in his statement of his continuing education from:

(1) Olive View Hospital

(2) Granada Hills Hospital

(3) University of California, Irvine

42. Respondent's certificate to practice medicine is further subject to discipline for violation of Business and

Professions Code section 2234, subdivision (e), in that he committed acts involving dishonesty and/or corruption which are substantially related to the qualifications, functions, or duties of a physician and surgeon, as more particularly alleged as follows:

A. Respondent committed perjury in his deposition in the case of Julie J[redacted] v. Milos Klvana, M.D.

B. Respondent advised Julie J. to dispose of the corpse of Amanda H. without notifying the authorities.

C. Respondent lied to Karen N. about hospitals in which he could deliver her baby.

D. Respondent lied to a hospital medical staff committee in telling them that Karen N. refused a caesarean section.

E. Respondent lied to Northridge Hospital regarding his membership in the county medical society.

F. Respondent lied to Tosha L. in telling her that he was administering vitamins and minerals to her when, in fact, he was administering Pitocin.

G. Respondent counseled Tosha L. to lie to the authorities about the circumstances of her labor and delivery.

H. Respondent falsely assured Elizabeth A. that in the event of an emergency he would accompany Lorraine A. to a hospital.

I. Respondent lied to representatives of the Board of Medical Quality Assurance regarding his medical care and treatment of Mira G., Julie J., and Karen N.

J. Paragraph 40 is incorporated by reference herein as though fully set forth at this point.

K. Paragraphs 41 A - 41 F are incorporated by reference as though fully set forth at this point.

43. Respondent's certificate to practice medicine is further subject to discipline for violation of Business and Professions Code section 2264, in that he has employed, directly and/or indirectly and aided and/or abetted unlicensed persons to engage in the practice of medicine and/or a mode of treating the sick or afflicted which requires a license to practice. The facts and circumstances are as follows:

A. Respondent has aided and abetted Lucile Schober, a chiropractor, in that chiropractor's practice of medicine at respondent's office at Newhall, California.

B. Respondent aided and abetted Lucile Schober's practice of medicine in the care and treatment of Tosha and newborn Regan L.

C. Respondent aided and abetted and employed Delores Doyle, an unlicensed person, in Delores Doyle's prenatal care and/or delivery of:

(1) Sandi S.

(2) Virginia N.

(3) Shirley J.

(4) Mary Kay G.

(5) Eunice V.

D. Respondent aided and abetted and Laura Rodriguez, an unlicensed person, to administer physical examinations to

Lanna D.

E. Respondent referred the obstetrical care of Michelle D. to respondent's unlicensed associate, Linda Pellegrin.

44. Respondent's certificate to practice medicine is further subject to discipline under Business and Professions Code section 810, subdivision (a) in that he knowingly presented false and/or fraudulent insurance claims as set forth in paragraph 41 E, which is incorporated by reference as though fully set forth at this point.

45. Respondent's certificate to practice medicine is further subject to discipline under Business and Professions Code section 2232 in that:

A. In January and February 1988 respondent possessed Schedule II, III, and IV controlled substances without having a registration issued by the Drug Enforcement Administration to do so.

B. In January and February 1988 respondent dispensed and administered Schedule III and IV controlled substances without having a registration issued by the Drug Enforcement Administration to do so.

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WHEREFORE, complainant prays that a hearing be held, and that following said hearing, a decision issue:

1. Revoking or suspending physician's and surgeon's certificate number A-29719 heretofore issued to respondent; and

2. Taking such other action as is just and proper.

DATED: March 30, ,1988.

KENNETH J. WAGSTAFF
Executive Director
Board of Medical Quality Assurance
Department of Consumer Affairs
State of California

Complainant

REDACTED

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MILOS KLVANA, M.D. 24456½ Lyons Avenue Newhall, California 91321 Physician's and Surgeon's Certificate No. A 29719, Respondent.	Board Case No. D-3572 OAH No. S E C O N D S U P P L E M E N T A L A C C U S A T I O N

DIXON ARNETT ("Complainant"), for causes for further discipline, alleges:

PARTIES

46. Complainant makes and files this Second Supplemental Accusation solely in his official capacity as Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California.

/

Updated License History and Status

47. On or about October 31, 1975, the Board of Medical Quality Assurance[1/] issued Physician's and Surgeon's Certificate No. A 29719 to MILOS KLVANA, M.D. ("respondent"). On or about March 14, 1980, the Board of Medical Quality Assurance ("Board") revoked respondent's physician's and surgeon's certificate, but stayed said revocation and placed the certificate on probation for five (5) years, pursuant to its February 13, 1980 Decision and Order in the case entitled "In the Matter of the Accusation Against Milos Klvana, M.D.," Board Case No. D-2248 (OAH Case No. 17972).[2/] On or about August 17, 1981, the Board modified the probationary terms and conditions by its July 16, 1981 order in said Board case (OAH Case No. N-16934). On or about March 3, 1983, the Board granted respondent's petition to terminate probation and hence restored respondent's certificate to full force and effect (OAH Case No. N-20157). On or about June 30, 1988, respondent's certificate expired and has not been renewed since its expiration.

48. On or about March 2, 1988, in the case entitled, "Board of Medical Quality Assurance v. Milos Klvana, M.D.," Los

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1. On January 1, 1990, the Board of Medical Quality Assurance became the Medical Board of California.

2. The instances of unprofessional conduct which constituted grounds for this 1980 disciplinary action were: [1] a 1979 conviction of 26 counts of violating Health and Safety Code §11154 (prescribing a controlled substance to a person who is not under treatment for a pathology or condition other than addiction to a controlled substance), and [2] prescribing, to persons not under his care for a pathology or condition, controlled substances without a good faith prior examination or without medical indication therefor.

Angeles Superior Court case no. C 678202, the Honorable Miriam Vogel, Judge of the Los Angeles County Superior Court, issued a Temporary Restraining Order against respondent's physician's and surgeon's certificate.

49. On or about April 13, 1988, Judge Vogel ordered that a Preliminary Injunction issue against respondent's physician's and surgeon's certificate. The Preliminary Injunction, duly served on all apparently interested parties, provided that: (1) respondent shall not practice medicine, (2) respondent shall not supervise physician's assistants, (3) respondent shall not violate the Medical Practice Act, (4) respondent shall not possess, order, purchase, furnish, receive, prescribe, dispense, administer, or otherwise distribute dangerous drugs or controlled substances, (5) respondent shall not possess, order, or receive any DEA 222c forms, (6) respondent shall not possess, order, or receive any blank prescription pads or unused triplicate forms, and (7) the Preliminary Injunction shall remain in effect until further order of the Court. Said preliminary injunction currently is in full force and effect.

JURISDICTION AND LEGAL AUTHORITY

50. The allegations of paragraphs 1 through 24, inclusive, of the Accusation on file in this case are realleged as if fully set forth herein.

51. The allegations set forth in the Notice of Amendment to Accusation, on file in this case, are realleged as if fully set forth herein.

52. The allegations of paragraphs 25 through 45, inclusive, of the First Supplemental Accusation on file in this case are realleged as if fully set forth herein.

53. Business and Professions Code ("B&P") § 2236 declares in pertinent portion that:

> "(a) The conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.
>
> "(b) The division may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if such conviction is of an offense substantially related to the qualifications, functions, or duties of a physician and surgeon. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a physician and surgeon is deemed to be a conviction within the meaning of this section.
>
> "(c) Discipline may be ordered in accordance with Section 2227, ... when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal ..."

54. B&P § 490 allows a board to "suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the

qualifications, functions, or duties of the business or profession for which the license was issued . . ."

CRIMINAL CONVICTIONS

55. On or about February 5, 1990, in the case entitled, "People of the State of California v. Milos Klvana," Los Angeles Superior Court Case No. A791288, respondent was convicted via jury trial of violating the following provisions of law:

Code §§ Violated	No. of Counts [Criminal Complaint][3]
*Penal §187(a) [Second Degree Murder, a felony]	9 [Count nos. 1-4,8,20,23,25,31]
*B&P §2053 [Aiding and Abetting the Unlicensed Practice of Medicine, a felony]	5 [Count nos. 10,22,27,30,33]
*Penal §182(1)/B&P §2053 [Conspiracy to Practice Medicine Without a License, a felony]	1 [Count no. 52]
*Insurance §556(a)(3) [Preparing Fraudulent Insurance Claim, a felony]	19 [Count nos. 5,11-13,15-17,29, 36-41,44-46,49,50]
*Insurance §556(a)(1) [Presenting Fraudulent Insurance Claim, a felony]	10 [Count nos. 6,14,18,28,34-36, 47,48,51]
*Penal §487(1) [Grand Theft, a felony]	2 [Count nos. 7,19]
*Penal §118 [Perjury by Declaration, a felony]	2 [Count nos. 42,43]

3. The "count numbers" from the "Criminal Complaint" correspond to the criminal counts set forth in the Amended Information filed in Los Angeles Superior Court case no. A791288. For sake of convenience, reference is made throughout this Second Supplemental Accusation to the count numbers in said Amended Information.

56. The facts and circumstances behind respondent's nine second degree murder convictions[4/] are detailed in People v. Klvana (1992) 11 Cal. App. 4th 1679. Those facts and circumstances are summarized briefly as follows. Respondent, who resigned from residency programs in obstetrics-gynecology and anesthesiology due to his deficient medical judgment and a resultant patient death, was warned by one supervisor that he had a cavalier attitude and should avoid fields of medicine which require moment-to-moment attention to patient status. In 1977, respondent proceeded to pursue a career in obstetrics in Southern California but experienced difficulty maintaining privileges at the various hospitals where he practiced. In 1980, respondent purchased the Diet-Rite Medical Clinic and commenced performing outpatient vaginal delivery of babies at said clinic. In his obstetrical practice, respondent utilized the services of non-physicians in monitoring pregnancies, performing deliveries, and providing follow-up care.

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4. A summary of the murder convictions:

Criminal Count No.	Surname of Infant's Mother	Date of Death
1	J[redacted]	[redacted]
2	F[redacted]	[redacted]
3	J[redacted]	[redacted]
4	G[redacted]	[redacted]
8	D[redacted]	[redacted]
20	E[redacted]	[redacted]
23	F[redacted]	[redacted]
25	P[redacted]	[redacted]
31	L[redacted]	[redacted]

From 1982 through 1986, respondent maliciously caused the deaths of at least nine infants which he delivered. Among the many factors behind the deaths are these: Respondent repeatedly ignored obvious, basic indicia of high-risk pregnancies (e.g., meconium[5/] staining, Rh factor) and failed to monitor or manage said risks properly (e.g., lack of emergency hospital referral, insufficient fetal monitoring, failure to provide neonatal care). Respondent disregarded multiple warnings from peers about inadequacies in his practices (e.g., the need for high-risk deliveries to be performed in a hospital). Respondent repeatedly omitted and/or misrepresented material information about his professional standing (licensure, hospital privileges), about the sophistication of his practice (clinic equipment, ability to handle emergencies), and about the patient's medical options (e.g., advisability of Caesarean section delivery). Respondent repeatedly administered the drug Pitocin improperly and failed to manage the risks presented by said drug. Respondent instructed patients reporting infant distress to stay away from hospitals or other emergency care. Respondent repeatedly requested that the parents of the deceased infants assist him in suppressing facts about their child's death.

57. The facts and circumstances behind respondent's convictions of violating B&P §2053 (Aiding and Abetting the Unlicensed Practice of Medicine) were charged and found as follows: Delores Doyle (a "certified nurse assistant" and

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5. Meconium is fetal excrement. The presence of meconium is an indication of fetal distress.

respondent's co-defendant in Los Angeles Superior Court case no. A791288) has not at any time held a license to practice medicine in the State of California. Between November 9, 1983 and June 17, 1985, inclusive, respondent and Delores Doyle wilfully and unlawfully practiced and attempted to practice medicine, advertised and held themselves out as practicing, a system and mode of treating the sick and afflicted in this state, and did diagnose, treat, and operate for an ailment, deformity, disease, disfigurement, disorder, injury and other physical and mental condition of persons, to wit, LANNA D[redacted] AND AARON D[redacted] [count 10], KIM E[redacted] AND TYRONE E[redacted] [count 22], ARLEEN P[redacted] AND VERONICA P[redacted] [count 27], LORRAINE A[redacted] [count 30], and TOSHA W[redacted] L[redacted] [count 33] under circumstances and conditions which caused or created risk of great bodily harm, serious physical or mental illness, and death, without Delores Doyle having at the time of so doing a valid, unrevoked, or suspended license and certificate.

58. The facts and circumstances behind respondent's conviction of violating Penal Code § 182[1] (Conspiracy to Commit a Crime, to wit, B&P §2053, Practicing Medicine Without a License) were charged and found as follows: from on or about September 1982 through October 1986, respondent and other individuals wilfully and unlawfully conspired together to practice medicine without a license. Pursuant to said conspiracy and for the purpose of carrying the objects and purposes of the conspiracy, respondent and other individuals committed numerous overt acts involving (1) the actual provision of obstetrical care and man-

agement by a person not licensed to practice medicine during the prenatal, labor, delivery, and post-partum phases of the pregnancies of numerous women; (2) the falsification of insurance claims as to the true provider of the obstetrical care, the circumstances under which babies were delivered (e.g., home, clinic), and the charges incurred during the obstetrical care; (3) the falsification of Certificates of Live Birth; (4) concealment of remuneration to the unlicensed practitioners of medicine.

59. The facts and circumstances behind respondent's convictions of violating Insurance Code §556(a)(3) (Preparing Fraudulent Insurance Claims) were charged and found as follows: respondent wilfully, unlawfully, and knowingly prepared, made, and subscribed to writings with intent to present and use said writings and to allow the said writings to be presented and used in support of a false and fraudulent claim for payment, as set forth in the chart below--

Criminal Count	Dates	Patient (p) or Victim (v)	Claim $$
5	11- 9-82 to 2-10-83	Mira G[redacted] (p)	$1,400.00
11	10-30-83	Lanna L[redacted] D[redacted] (p)	$3,468.00
12	10-30-83	"	"
13	9-30-83	"	"
15	8-22-83 to 12-29-83	"	"
16	8-22-83 to 12-29-83	"	"
17	12-21-83 to 12-29-83	"	"

[c o n t i n u e d]

Criminal Count	Dates	Patient (p) or Victim (v)	Claim $$
29	1-10-86	Hartford Insurance (v)	$ 645.00
36	4-29-86 to 7-21-86	Union Labor Life Insurance (v)	$ 555.00
37	6-23-86	Tosha W[redacted] L[redacted] (p)	$ 325.00
38	4-29-86 to 7-21-86	"	$ 335.00
39	4-29-86 to 7-21-86	"	$ 565.00
40	7-16-86	"	$ 900.00
41	7-18-86	Daniel L[redacted] (p)	$ 555.00
44	2-10-83	Sandi S[redacted] (p)	$1,300.00
45	3-10-83	"	$ 700.00
46	3-10-83	Prudential Insurance (v)	$2,000.00
49	1-15-84	Ruby R[redacted] C[redacted] (p)	$1,930.00
50	1-15-84	"	$ 700.00

60. The facts and circumstances behind respondent's convictions of violating Insurance Code §556(a)(1) (Presenting Fraudulent Insurance Claims) were charged and found as follows: respondent wilfully, unlawfully, and knowingly presented and caused to be presented false and fraudulent insurance claims for payment, under contracts of insurance against loss, as set forth in the chart below--

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Criminal Count	Dates	Insurance Company	Claim $$
6	2-10-83	Blue Cross of California	$1,400.00
14	11-18-83	Prudential Insurance	$3,468.00
18	12-29-83	"	"
28	11- 5-85 to 2-27-85	Amer. Consulting Engineers Council Trust Fund / Hartford Insurance	$ 465.00
34	5-31-86 to 7- 2-86	AFTRA Pension and Welfare Funds / Union Labor Life Ins. Co.	$ 325.00
35	4-29-86 to 7-21-86	AFTRA Pension and Welfare Funds / Union Labor Life Ins. Co.	$ 900.00
36	4-29-86 to 7-21-86	AFTRA Pension and Welfare Funds / Union Labor Life Ins. Co.	$ 555.00
47	3- 4-83	Prudential Insurance	$1,300.00
48	3-14-83	Prudential Insurance	$2,000.00
51	1-15-84 to 2-13-84	Prudential Insurance	$2,630.00

61. The facts and circumstances behind respondent's convictions of violating Penal Code §487(1) (Grand Theft) were charged and found as follows:

a. Count 7 - On or about April 5, 1983, respondent willfully and unlawfully took $1,060.64 from Blue Cross of California.

b. Count 19 - Between December 1, 1983 and February 9, 1984, respondent willfully and unlawfully took $1,713.80 from Prudential Insurance Company.

62. The facts and circumstances behind respondent's convictions of violating Penal Code §118 (Perjury by Declaration) were charged and found as follows:

a. Count 42 - On or about March 2, 1981, respondent testified, declared, deposed, and certified under penalty of perjury before the Board of Medical Quality Assurance in respondent's Petition for Modification of Probation (referenced in paragraph 47 supra), and in giving that declaration and/or testimony, he wilfully stated as true material matter which he knew to be false, to wit: (1) that he was Board Eligible in Obstetrics-Gynecology, (2) that he had not been disciplined by any hospital or health facility for a medical cause or reason since the effective date of the Board's most recent disciplinary action against him, (3) that his only post-graduate training was at De Paul Hospital in Norfolk, Virginia in 1970-71 and at Kings County Hospital in Brooklyn, New York in 1971-74, and (4) that the "only hospital in area is deniing [sic] my privileges because I cannot prescribe class II and III drugs."

b. Count 43 - On or about September 5, 1982, respondent testified, declared, deposed, and certified under penalty of perjury before the Board of Medical Quality Assurance in respondent's Petition for Termination of Probation (referenced in paragraph 47 supra), and in giving that testimony and/or declaration, he wilfully stated as true material matter which he knew to be false, to wit: (1) that he was Board Eligible in Obstetrics-Gynecology, (2) that he had not been disciplined by any hospital or health facility for a medical cause or reason

since the effective date of the Board's most recent disciplinary action against him, (3) that the reason he was unsuccessful in getting on staff at Valley Vista Hospital was that his medical license was on probation, and (4) that his only post-graduate training was at Kings County Hospital in Brooklyn, New York in 1971-74.

63. The convictions set forth supra are now final.

OTHER MATTERS

64. B&P § 2227 states in pertinent part that:

"A licensee whose matter has been heard by the Division of Medical Quality, ... or by an administrative law judge, or whose default has been entered, and who is found guilty may, in accordance with the provisions of this chapter:

(a) Have his or her certificate revoked upon order of the division.

(b) Have his or her right to practice suspended for a period not to exceed one year upon order of the division...

(c) Be placed on probation upon order of the division...

(d) Publicly reprimanded by the division...

(e) Have such other action taken in relation to discipline as the division...or an administrative law judge may deem proper."

PRAYER

65. For the reasons set forth in paragraphs 1 through 64, inclusive, of the Accusation, Notice of Amendment to Accusation, First Supplemental Accusation, and Second Supplemental Accusation on file herein, good cause exists to impose discipline on the physician's and surgeon's certificate issued to respondent.

WHEREFORE, complainant prays that a hearing be held upon the Accusation, Notice of Amendment to Accusation, First Supplemental Accusation, and Second Supplemental Accusation on file herein, and that the Division of Medical Quality of the Medical Board of California make its order:

1. Revoking Physician's and Surgeon's Certificate No. A29719, issued to MILOS KLVANA, M.D.; and

2. Taking such other and further action as may be deemed proper and appropriate.

DATED: 29 APRIL 1993

for Elsa B. Wolfe D.A.G.
DIXON ARNETT
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant